



Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care

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Inequality in Quality

- Growing emphasis on public reporting on clinical performance (process measures)
- Concern about perverse incentives
- Increased enrollment of publicly funded beneficiaries in managed care arrangements
- Disparities not widely perceived to be an essential component of poor quality

Reperfusion Therapy in Medicare Beneficiaries with Acute MI

Group	% Eligible receiving
reperfusion	
White men	59%
White women	56%
Black men	50%
Black women	44%

Canto JG; Allison JJ; Kiefe CI; Fincher C; Farmer R, Sekar P; Person S; Weissman NW. Relation of race and sex to the use of reperfusion therapy in Medicare beneficiaries with acute myocardial infarction. N Engl J Med 2000 Apr 13;342(15):1094-100.



Non-clinical Determinants of Health Outcomes

- Patient characteristics
- Practitioner characteristics
- Hospital or setting characteristics
- Patient preferences
- Reimbursement

SES, Gender and Health Status

	ADL limitations	3 or more chronic conditions
Education <12 yrs vs. > 12 yrs	1.9*	1.9*
Income < \$10,000 vs. > \$25,000	1.9*	1.5*
African-American vs. White	1.5*	1.6*

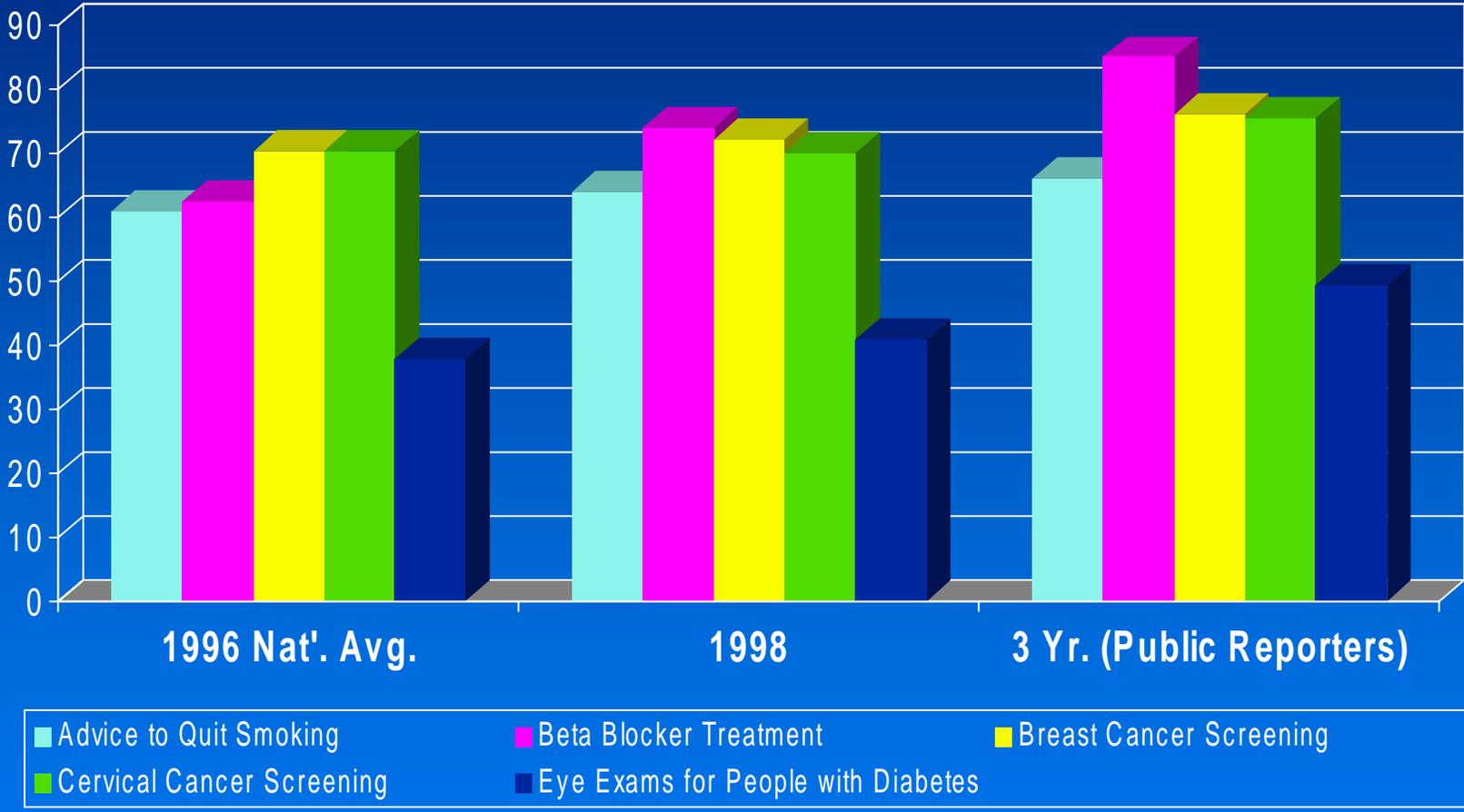
Age-Adjusted odds ratios

*p < .001

Inequality in Quality: Principles

- Disparities associated with socioeconomic position, race and ethnicity represent a critical quality opportunity
- Need for relevant and reliable data
- Performance measures should be *stratified*
- Population-wide measures should be *adjusted*
- Account for SEP **and** race / ethnicity

NCQA's State of Managed Care Quality



Source: NCQA, Washington, DC



Implementation Challenges

- Leadership (multifocal)
- Absence of data
- Privacy and data collection concerns and strategies
- Misuse of data
- Health care organization resistance and inertia

Persistent Controversies

- What proportion of observed disparities are attributable to health *care*?
- Boundaries of accountability
- Is less more?
- Do we know enough to intervene?

Whither Data??

- No clear description of what currently exists within health plans, or how relevant data c(sh)ould be collected
- Exploratory meeting held: MCO leaders, employers, others sponsored by OMH, Commonwealth Fund and AHRQ



Major Themes - 1

- Variability in current capacity re. Data on race and ethnicity
- Should this only be applied to MCO's?
- Do we know enough to intervene?
- Potential employer / purchaser interest
- HOW to collect data -- accurately and efficiently -- remains a big challenge



Major Themes - 2

- Concerns about perceived misuse of data; privacy of personal health information
- Concerns about potential legal barriers (“redlining”; liability)
- Strong interest in the business case for collecting requisite data
- Data on income and education much more difficult to obtain*

AHRQ Task Orders In Progress

- In 2000 AHRQ started a new Integrated Delivery System Research Network (IDSRN)
- One task order given to Denver Health to examine the capacity to conduct studies on the impact of race / ethnicity on access, use and outcomes of care
- One task order given to United Health Care and RAND to examine variations in cardiac performance measures (r/e and SES)



Capacity of IDS's to Conduct Research on Race / Ethnicity

- Intermountain Health Care; Providence Health System; CareOregon; Summa (NE Ohio); University of Pittsburgh; UNC
- Denver Health (1 hospital; 11 clinics)
- New York-Presbyterian Hospital System (31 hospitals; 100 clinics)

[Do not collect as a matter of policy]



Capacity - 2

- 1. Describe in detail data on race / ethnicity
- 2. Analyze the utility of each distinct data set for research, and identify strategies to enhance that capacity
- 3. Specific data sets that could be used to conduct studies on r/e and access and outcomes
- 4. Present results to chief clinical officers

“It is not possible to learn without measuring, but it is possible-- and very wasteful-- to measure without learning.”

Donald Berwick, 1998